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Emotional characteristics of mothers of children admitted with anorexia complaint

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Abstract
Aim: It is aimed to compare the emotional characteristics of the mother and the emotional characteristics of the mother mostly in the families of children with no appetite.
Material and Methods: Among the children who came to the outpatient clinic for routine checks, mothers of 56 first consecutive children between the ages of 3-8 who had been suffering from anorexia for the last three months were included in the study. The first 39 consecutive healthy children were taken as the control group. A personal information form, Eating Attitude Test (EAT), State-Trait Anxiety Inventory (STAI), Beck Depression Inventory (BDI), Brief Symptom Inventory (BSI), Young Schema Questionnaire (YSQ) and Family Assessment Device (FAD) that measures anxiety levels were given to all mothers who agreed to participate in the study.
Results: There was no difference between the control group and the mothers of children with anorexia in terms of EAT, STAI and BDI. According to the BSI scores of the mothers of children with anorexia, depression and anxiety symptom levels were found to be higher than in the control group ($p<0.05$). The scheme of abandonment from the subtests of YSQ was found to be different between the case and the control group ($p=0.041$). According to the subtests of FAD, it was determined that the mothers of children with anorexia had problems with family functions, problem solving, communication and roles.
Discussion: We suggest that all family members should be involved, especially in communication, roles and problem solving in the family. In the anorexia problem, especially the approach in which the child and father will be evaluated is especially useful.

Keywords
Anorexia, Eating Attitude, Depression Inventory, Symptom Inventory, Schema Questionnaire, Family Evaluation

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Introduction

Children who do not have an organic problem, who applied to the outpatient clinic with anorexia and eating rejection, were defined as infancy anorexia in DSM-IV, and were evaluated in detail in the pediatric psychiatry outpatient clinics in DSM-V in terms of avoidant/ restrictive nutrient intake disorder [1]. It is reported that 30% of applicants with anorexia complaints have organic problems. However, it should not be overlooked that factors related to psychological and social anorexia may also occur in children with organic problems. Indeed, if anorexia occurs in relation to another condition or disorder, if this condition or disorder is more severe than it may cause, and the impact of these factors should be evaluated by the child psychiatrist [2-6].

Whether an organic diagnosis is evaluated or not, mothers often play the leading role in the diet. There are many studies on infants' anorexia, eating rejection, or eating/nutritional disorders that reveal problems in mother-child interaction. In the studies examining mother-child interaction during feeding, separation anxiety, depression, somatic symptoms and attachment crises were found in children with anorexia, and anxiety, depression and inappropriate nutritional attitudes were found higher in mothers [7-9].

Anorexia is a very common problem in pediatrics outpatient clinics. It has been reported that anorexia and nutritional problems are seen at high rates such as 25% in normally developing children, 80% in children with developmental retardation and 90% in children with autism [9]. The huge difference between the rates of application to the pediatrics outpatient clinic due to anorexia is that psychosocial factors are less thought by families and pediatricians. For this reason, hypothesis has been established that it can be very useful to refer children to psychiatry to think about psychological factors with questionnaires after organic examinations.

In this study, it was aimed to evaluate the emotional characteristics of the mothers of the children brought to the clinic with the complaint of anorexia.

Material and Methods

This study was followed up at the Canakkale Onsekiz Mart University Medical Faculty Hospital, the healthy Child outpatient clinic, and was applied to 3-8 years old children and their mothers who applied to the outpatient clinic for control purposes. Among the children who came to the outpatient clinic for routine controls, mothers of the first 56 children who agreed to participate in the study, who had been suffering from anorexia for the past three months, were taken as the study group. The first 39 healthy children who applied to the robust child outpatient clinic who came to the routine development follow-up and did not have anorexia complaints were taken as the control group. Children with chronic disease and/or children with any current disease were excluded from the study. Approval was obtained from Canakkale Onsekiz Mart University Clinical Research Ethics Committee Presidency with the decision numbered 2015-20 on 09.12.2015 for our research no. 2011-KAEK-27/2015-153.

Criteria for inclusion in the research were as follow:

1- Being in the normal percentile in the growth curve of the child during the physical examination

2. The child does not have any chronic disease

3. Having healthy children between the ages of 3-8

4. Agree to participate in the study

Criteria for exclusion from the research:

1. Having neurodevelopmental psychiatric diseases such as hyperactivity and autism

2. No motor mental retardation or anatomical defect affecting nutrition

3. No catabolic diseases such as tuberculosis, immunodeficiency

4. Infection causing chronic gastrointestinal symptoms such as nausea, vomiting, dysphagia, gastroesophageal reflux disease, esophagitis, gastritis, duodenitis, peptic ulcers, gastroenteropathy, causes of chronic diarrhea, malabsorption (Celiac, etc.), food reactions, chronic constipation, functional bowel diseases not having parasites.

5. People with known nutritional deficiency, severe malnutrition, iron deficiency anemia

6. Anorexigenic drug use

7. Causes that disrupt metabolism. Metabolic diseases: Hereditary fructose intolerance, urea cycle defects, organic acidemias... etc.

8. Those with long-term enteral or parenteral anamnesis

9. Supportive radiological and laboratory findings suggestive of organic causes.

All mothers who agreed to participate in the study were given a Personal information form, Family Assessment Device (FAD), Eating Attitude Test (EAT), State- Trait Anxiety Inventory(STAI), Beck Depression Inventory (BDI), Young Schema Questionnaire (YSQ) and Brief Symptom Inventory (BSI).

Personal information form:

With the "Personal Information Form" prepared by the researchers, questions were asked including socio-demographic characteristics such as gender, age, education level of the mother, social security, place of residence, information about work, age, education level, diseases, divorce separation, and previous history of psychosocial symptoms.

Family Assessment Device (FAD):

McMaster Family Assessment Device (FAD). The FAD is a 60-item self-report questionnaire used by clinicians and researchers to evaluate family functioning. FAD was completed by all household members aged 12 years and older [10]. TThere are studies in which attitude of the family was assessed by administering FAD only to mother [11]. The FAD was designed to assess whole family functioning according to multiple family members' perceptions. Validity and reliability in Turkish have been fulfilled [12]. The scale involved seven subscales: general function, problem solving, communication, roles, affective responsiveness, affective involvement, and behavioral control [10].

Eating Attitudes Test (EAT):

The EAT contains 40 items, including items related to symptoms and behaviors common to patients with eating disorders, and provides an index of the severity of the disorder. Validity and reliability in Turkish have been fulfilled [13].

State-Trait Anxiety Inventory (STAI):

State-Trait Anxiety Inventory is a self-report questionnaire consisting of 2 sub-scales (state anxiety and trait anxiety), each

including 20 items evaluating the level of anxiety. The State anxiety (STAI-S) describes the person's feelings at a specific moment and under particular conditions, whereas trait anxiety scale (STAI-T) is used to describe how subjects generally feel. Responses to each item in the anxiety questionnaire are assigned a score from 1 to 4. Possible scores vary from 20 to 80, with higher scores indicating more anxiety [14].

Beck Depression Inventory (BDI):

Beck Depression Inventory has been used in numerous studies of depression and was completed on all major assessment points [15]. Validity and reliability in Turkish have been fulfilled [16].

Young Schema questionnaire-Short Form-3 (YSQ-SF3):

YSQ-SF3 was developed and determined early maladaptive schemas by Young et al. [17]. The scale contains 90 items. There are 5 schema domains and 18 different maladaptive schemas. Each item is rated on a 7-point scale ranging from 1 (entirely untrue for me) to 7 (describes me perfectly). Higher scores represent more maladaptive schemas. Validity and reliability in Turkish have been fulfilled [18].

Brief Symptom Inventory (BSI):

The Symptom Checklist-90-Revised is a 90-item self-report symptom inventory, and is a measure of current psychological symptom status and is scored on nine subscales. Validity and reliability in Turkish have been fulfilled [19].

Statistical analysis

SPSS 13 computer program was used for statistical analysis in the study. Variables that receive continuous values in the study will have a mean, standard deviation, maximum and minimum values. In variables that show normal distribution from continuous variables, comparisons between the two groups were used, independent of parametric tests. The Mann-Whitney U test was used for comparison of variables that do not show a normal distribution between the two groups. The significance level of 95% ($p < 0.05$) will be accepted in the study.

Results

The average age of 56 children in the case group was 3.7 ± 1.3 years, and 3.9 ± 1.2 years of 39 children in the control group. There were 49 girls (87.5%) and 7 boys (12.5%) children in the case group with anorexia. There were 36 (92.3%) girls and 3 (7.7%) girls in the control group without anorexia. There was no significant difference in terms of gender and age in the two groups ($p>0.05$).

The average age of the mothers was 33.1 ± 4.8 years in the case group and 31.5 ± 4.6 in the control group. The mean age of the mothers in the case group during the birth of the child was 29.3 ± 4.8, and the control group was 27.1 ± 3.6. There was no significant difference between the two groups in terms of the average age of the mothers for participation in the study and at birth ($p>0.05$). The average age of the fathers was 36.5 ± 6.0 in the case group and 34.5 ± 5.0 in the control group. There was no significant difference between the two groups in terms of the average age of the fathers' participation in the study ($p>0.05$).

While 22 (39.3%) in the case group and 16 (41.0%) in the control group had secondary or lower education; 34 (60.7%) mothers in the case group and 23 (59.0%) mothers in the control group received education in high school and above. The difference between the education levels of the mothers in the case and control groups was not significant ($p>0.05$).

There was no significant difference between the two groups in terms of whether mothers worked or not, and a history of mental and physical illness in mothers. There was no significant difference between the two groups in terms of whether fathers worked or not, and a history of mental and physical illness in fathers. There was no significant difference between the groups in terms of mental illness history in mothers. There was

Table 1. Comparison of the mean scores of the mothers

	Case (n=56) Mean±SD	Control (n=39) Mean±SD	t	p
Eating Attitude Scale	16.95±9.38	18.67±11.33	-0.807	0.42
Beck depression scale	12.12±8.94	11.28±10.36	0.423	0.67
FAD Problem Solving	12.09±3.66	9.49±3.46	3.482	0.001*
FAD Communication	16.57±4.71	13.33±4.69	3.305	0.001*
FAD Emotional Response	10.14±4.038	8.79±2.667	1.824	0.007*
FAD Showing the Necessary Interest	15.88±2.76	15.26±2.29	1.149	0.25
FAD Roles	22.89±4.31	20.13±4.09	3.142	0.002*
FAD Behavior Control	19.73±3.24	19.18±3.25	0.817	0.41
FAD General Functions	19.77±4.91	17.59±3.65	2.351	0.020*
State Trait Anxiety Inventory-1	43.48±8.0	42.59±5.45	0.605	0.54
State Trait Anxiety Inventory-2	47.7±7.4	46.97±7.60	0.473	0.64

t: t test, SD: Standard Deviation. FAD: Family Assessment Device

Table 2. Comparison of the Brief Symptom Inventory (BSI) subscale scores with and without anorexia

	Anorexia n: 56 Rank Average (Row Total)	Not Anorexia n: 39 Rank Average (Row Total)	U	P
Somatization	51,93	42,36	872.0	0.093
	-2908	-1652		
Obsessive	50,87	43,88	931.0	0.222
	-2848,5	-1711,5		
Interpersonal	43,74	50,16	926	0.256
	-2759	-1706		
Depression	53,18	40,56	802	0.026*
	-2978	-1582		
Anxiety	54,19	39,12	745.5	0.008*
	-3034,5	-1525,5		
Paranoid	49,62	45,67	1001.0	0.487
	-2779	-1781		
Psychoticism	52,18	42	858.0	0.070
	-2922	-1638		
Additional Items	54,47	38,71	729.5	0.005*
	-3050,5	-1509,5		
Total score	52,77	40,06	782.5	0.026*
	-2902,5	-1562,5		
Severity index	52,77	40,06	782.5	0.026*
	-2902,5	-1562,5		

* $p<0.05$ (Mann-Whitney U test).

Table 3. Comparison of Young Schema subscale mean scores with and without anorexia

	Anorexia n: 56	Not Anorexia n: 39	t	P
	Mean±SD	Mean±SD		
Emotional Deprivation	7,41±3,19	8,00±4,00	0,765	0,446
Failure	11,00±3,92	10,39±4,30	-0,713	0,478
Pessimism	10,62±4,97	11,89±4,89	1,24	0,218
Social Isolation	12,36±4,63	12,38±5,05	0,016	0,987
Suppressing Emotions	9,18±4,09	9,75±4,01	0,675	0,501
Approval Seeking	17,54±5,32	15,84±5,88	-1,468	0,146
Nesting Addiction	14,97±6,45	16,20±6,29	0,918	0,361
Privilege Insufficient Self-Auditing	19,56±6,24	18,77±5,56	-0,639	0,524
Sacrifice Yourself	15,74±3,72	14,46±4,66	-1,486	0,141
Abandonment	7,46±4,41	9,18±3,22	2,075	0,041*
Punished	20,36±5,91	19,29±5,49	-0,896	0,372
Imperfection	9,79±4,66	9,89±4,59	0,102	0,919
Vulnerability in the Face of Threats	10,00±3,96	10,54±4,62	0,605	0,547
High Standards	7,38±3,53	7,84±3,38	0,629	0,531

* p<0.05, Student t test; SD: Standard Deviation.

no significant difference between the groups in terms of the physical disease history of the mothers.

The results of Eating Attitude Scale, Beck Depression Inventory (BDI), State-Trait Anxiety Inventory (STAI-1-2) and Family Assessment Device (FAD) applied to mothers are shown in Table 1. The mean of BDI Depression scores of mothers of children with anorexia and mothers of children without anorexia was not significant (p = 0.67). There was no difference between the mothers of anorexia children and the mothers of anorexia mothers' eating attitude scale (p = 0.42), anxiety (p = 0.54) and anxiety (p = 0.63) anxiety scale scores. When the FES subscale scores were examined, there was no difference between the two groups in terms of showing the required attention (p = 0.25), emotional reaction (p = 0.07) and behavioral control (p = 0.41), while problem solving (p = 0.001), communication (p = 0.01), roles (p = 0.02) and general functions (p = 0.02) were found to be significantly different (Table 1).

A comparison of the Brief Symptom Inventory (BSI) subscale scores with and without anorexia is shown in Table 2. In the subscales of the short symptom inventory, anxiety, depression, additional items, total score and severity index were significantly higher in the case group (p<0.05).

The comparison of mean Young Schema subscale scores with and without anorexia is shown in Table 3. In the scheme scale, the abandonment score was higher in those without anorexia (p = 0.041).

Discussion

The anorexia complaint most often peaks between 6 and 36 months, the period of meeting new foods. Nutrition is a process influenced by many environmental, biological, social and psychological factors. Environmental factors include the uncertainty of mutually transmitted messages during feeding and/or play, excessive controlling or insensitive attitude of the caregiver, the primary caregiver not being open to cooperation, and the interaction between the caregiver and the baby [20].

Among these risk factors, parental anxiety and depression levels were evaluated in our study. In the subgroup tests of BSI used in our study, there was no significant difference in BDI and STAI scores, although the anxiety and depression scores were found to be high in the mothers of children with anorexia. Unlu et al. found that there was a significant difference in the mothers of children with FAD, BDI and STAI anorexia [8]. Ammaniti et al. stated that anxiety and depressive symptoms were significantly higher in the parents of children with anorexia of 6-36 months [21]. This may be related to the average age of children in our study group.

Unlu et al. reported that BDI scores were not different between those with and without malnutrition in the study group [8]. In addition, in terms of anxiety, Spielberg described the STAI scale as a relatively high anxiety in adults and above 40 points [22]. Both our control and anxiety group are above this value, suggesting that our control group is also anxious group.

Interaction and dynamics within the family are very important for anorexia in the child, not the direct parent or child [23]. Considering the FAD scores given for family evaluation in our study, there was a significant difference in FAD alt scale scores in terms of problem solving (p = 0.001), communication (p = 0.01), roles (p = 0.02) and general functions (p = 0.02). In our study, the fact that children with anorexia in the FAD general function subscale were significantly higher than that of the control group suggests that mothers perceive all family functions as unhealthy. We suggest that comparing the FAD score to siblings over the age of 12, if there is any other caregiver who lives with the father and the family and can provide additional information to the literature. In our study, it was applied only to the mother considering that the mother fed the child and the evaluation of the mother was more important. Unlu et al. found that FAD problem solving subscale score was significantly higher in the mothers of children with famous and anorexia than the control group [8]. Similarly, in our study, problem-solving scores were found to be significantly higher in this subscale. It may be thought that mothers of children with anorexia apply wrong methods to solve the eating problem of their mothers, or they cannot continue to use the right methods in sufficient time and to a sufficient degree.

In our study, the fact that the FAD communication subscale score was significantly higher in the families of children with anorexia compared to the control group indicates the relationship between communication problems in the family or mother-child relationship in anorexia. Problems in mutual communication suggest that the mother may misunderstand her child's wishes or needs, and exaggerated, and overly rigid reactions may force the child to eat unwanted amounts rather than appropriate answers [24].

Limitations of our study: The choice of the control group as a hospital caused higher anxiety levels. The absence of the child, father, older siblings, or even grandparents in extended families may have caused mothers to enter a defensive setup, which would emphasize factors other than herself when she filled in the questionnaire.

Conclusion

In conclusion, depression and anxiety scores were higher in BSI in mothers of children with anorexia or refusal to eat. When

we think that both groups are formed in an anxious mother group, it is concluded that the dynamics within the family such as roles, communication and problem solving are important in the family, and it is useful to carry out further studies on these issues according to the FAD scale filled by the mother. Family functions and mother-child interaction should be evaluated well in children with anorexia. In treatment approaches, considering the only problem as a mother, there will be incomplete and incorrect evaluation. In an assessment, in which the mother is taken to the center, it will be difficult to give healthy results. It is concluded in our study that the roles of everyone in the family should be evaluated.It can be argued that efforts to solve the problems, in which the mother has difficulties but cannot find support, the mother and child cannot establish emotional communication during conflicts, the efforts are regarded inadequate, or cannot be solved or comprehended, are important.

Scientific Responsibility Statement
The authors declare that they are responsible for the article's scientific content including study design, data collection, analysis and interpretation, writing, some of the main line, or all of the preparation and scientific review of the contents and approval of the final version of the article.

Animal and human rights statement
All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. No animal or human studies were carried out by the authors for this article.

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Conflict of interest
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